DRUG AND ALCOHOL RECOVERY OUTCOMES FRAMEWORK

Eibhlín Ní Ógáin & Lindsay Hodgson

Commissioned by the Health Research Board

MARCH 2017

Introduction

Background

Shared measurement involves using common tools to track outcomes across similar organisations and settings. It is both a process to understand a sector's shared outcomes and a tool that can be used by multiple organisations to track social impact.

Drug and Alcohol Task Forces (DATF) fund and run a number of services tackling various issues related to substance misuse. To date, many task forces have used logic models to understand their outcomes and have evaluated their work in different ways. However, as of yet there has not been a consistent approach to measuring outcomes across the many local and regional taskforces.

This project aims to develop a shared outcomes framework and a set of common measures for taskforces to begin tracking the impact of their work in a consistent way. It is hoped that this will enable better understanding of what works to promote recovery from drug and alcohol misuse, enable learning across services, taskforces and regions and allow evidence of what interventions are effective at a local context to be fed into national strategy.

Project goals

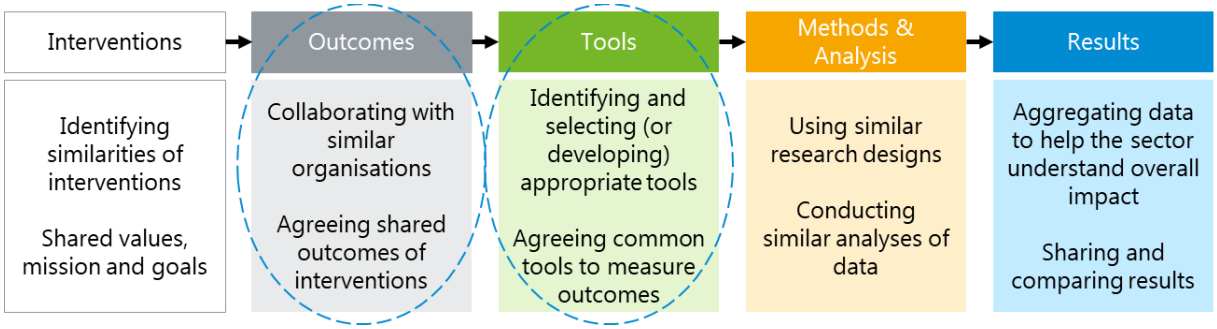
The first aim of this project is to support DATF to develop a common understanding of the outcomes their services lead to. This piece of work mostly focuses on personal soft outcomes - i.e. outcomes that are specific to an individual and relate to intrinsic change such as attitudes, interpersonal skills or emotional well-being. However, we also include other outcomes in the framework as it is impossible to think about recovery in this space without also covering change in drug use behaviour and hard outcomes such as entering employment and gaining a qualification.

The second aim of this project is to develop a list of recommended instruments that taskforces can use to measure outcomes that are relevant to their work. Each outcome in the shared framework has a recommended measure accompanying it - this is usually a questionnaire or psychometric scale.

Ultimately this project aims to support taskforces identifying and measuring the outcomes of their work. This is to understand whether projects are successful at helping individuals recover from drug and alcohol misuse, understand why different projects might be successful and compare the effectiveness of different interventions. However, using the measures in this framework will require commitment and support that go beyond the remit of this project. Successful use of shared measures requires further training for taskforces in using measures and analysing results, a software solution to store data and automate collection and reporting, ensuring that data is used for service improvement at the frontline and ensuring that funders use the same information in annual reporting. Guidance on how to successfully implement this framework is included in section 3.

Methodology

The development of shared measures for a sector follows a number of key stages. These stages are highlighted in the blueprint for shared measurement report which lays out best practice in developing shared measurement.[1] This blueprint was used to design the steps in this project. As DATF are already organised in an identified sector, we mainly focussed on stages 2 & 3 below.



To develop the shared outcomes framework for drug and alcohol taskforces we carried out the following activities:

- Desk research into the literature around recovery;
- Survey of taskforces to map services and outcomes;
- Calls with a number of taskforce coordinators to understand their work in more detail;
- Day long workshop to facilitate the brainstorming of taskforce shared outcomes.

This allowed us to develop a framework of outcomes that were highlighted by taskforces as being significant to their work and also appear in the literature on drug and alcohol recovery.

Service user consultation

Following a workshop with taskforces in April 2016 as well as telephone interviews and desk research, the first shared outcomes framework was developed in May 2016. This framework was developed in consultation with taskforces and had positive feedback from taskforce staff. However, the next step in testing the framework was to ensure that the outcomes were relevant and meaningful to service users. Ensuring that outcomes are relevant to service users will make the framework more meaningful and thus more likely to be implemented and used effectively. Including user input and feedback in this framework can:

- Ensure that the final outcomes framework is relevant to service user experience
- Ensure that outcomes are relevant to local needs
- Enable service users to voice their opinion on services
- Encourage a sense of ownership over the outcomes included in the framework
- Ensure that any measurement used is proportionate
- Ensure that language to describe the service user experience is accessible and where possible produced by service users themselves.

[1] Ni Ogain, E., De Las Casas, L and Svistak, M. (2013). *The Blueprint for Shared Measurement.* London: New Philanthropy Capital. http://www.thinknpc.org/publications/blueprint-for-shared-measurement/

As a result, a service user consultation process was run by four taskforces across Ireland in September and October 2016.

Service user consultation methodology

To support the service user consultation, a standard guidance pack was developed for taskforces to run their own consultations. This pack included detailed guidance on how to run the focus groups, including prompt questions to elicit feedback. There was separate guidance for both frontline staff and service users. The pack also included spreadsheets for taskforces to record all feedback from the workshops in a consistent way. Taskforces were then invited to a workshop in August to go through the guidance in the service user consultation pack and to clarify how to run the consultation process.

Following this, taskforces were invited to take part in the service user consultation. Four taskforces took part, they were: the North-East Regional Drugs & Alcohol Task Force the South East Regional Drugs & Alcohol Task Force, Dublin 10 Local Drugs & Alcohol Task Force and Dublin 12 Local Drugs & Alcohol Task Force. A total of 117 service users and 47 staff took part in the consultation across these locations. The consultation sought to answer: which outcomes service users discussed as relevant without looking at the outcomes framework; how relevant the outcomes in the draft framework were; whether there were any missing areas; and, what services helped most with recovery. The consultation was run throughout September and October 2016. Once the consultation was complete, all feedback was collated in a standardised spreadsheet.

Analysis of the feedback looked at outcomes services users mentioned without looking at the outcomes framework. This was to see whether there was consistency between the outcomes in the framework and outcomes mentioned by services users before being introduced to the framework. The analysis also looked at responses around the relevancy of outcomes in the current framework to see if any outcome needed to be removed. Finally, the analysis looked at the most frequent outcomes mentioned by service users that were missing in the May 2016 framework. As a result, changes were made to this version of the framework to incorporate the feedback from service users.

Findings from the service user consultation

Responses to the consultation were overwhelmingly positive. Analysis of outcomes mentioned by service users as playing a significant role in their recovery were all included in the draft outcomes framework. All the service users felt that the outcomes included in the first draft were relevant. There were a small number of outcomes that users identified that were not included in the first draft of the framework. These outcomes have now been included in the revised framework and new measures have also been listed for services to measure impact in these areas. The outcomes that were identified by service users most frequently as being missing in the first version of the outcomes framework were:

- Thinking differently
- Self-acceptance
- Reduced isolation
- Spirituality
- Access to childcare
- Appearance
- Self-medication
- Able to contribute/ having purpose

Other outcomes were mentioned by service users but we have only included those that emerged as common outcomes – i.e. was mentioned by more than one service user. In some

cases, outcomes similar to the above are already included in the framework. For example, self-acceptance is similar to aspects of self-esteem. In this case, we have altered the wording of outcomes to include these other alternative wordings. Isolation is also similar to the outcome of social networks – isolation may be the problem while social networks are the solution. The services that were identified most frequently by service users as helping with recovery were: counselling and psychotherapy, community based drug or outreach work, residential treatment and further education programmes. As a result of this feedback, this framework now includes new outcomes mentioned by service users as being significant to the recovery process. The framework also has new measures for each of these outcomes so services can track the impact they are having in these areas.

How this framework should be used

You can use this framework to identify outcomes that your project(s), intervention(s) or service(s) lead to for individuals you work with. This may be for a) services run directly by taskforces or b) services funded by taskforces. Before selecting outcomes, we would encourage you to think about the logic model or theory of change for your service or project. There are a number of guides on how to do this for an organisation or for an individual project. Developing a short theory of change in this way should help you to understand the intermediate outcomes of your service. Generally, a project should have three to five outcomes. Once you have done this, you can then see which of your outcomes matches the shared outcomes in this framework. Use the framework to locate your outcome and then find the recommended measure that accompanies it. For guidance on theory of change and measurement, we recommend using the Journey to Employment toolkit.[2]

Section 1

Section 1 identifies the factors that contribute to drug and alcohol recovery. Based on evidence from the literature and insights from a survey, calls and a workshop with taskforces, this section presents our framework for understanding a person's recovery from drug and alcohol misuse. It identifies five groups of factors that contribute to successful recovery: (1) Attitudes and feelings; (2) Employment and skills; (3) Relationships; (4) Personal circumstances and needs; and (5) Drug use behaviour. It is a visual tool to help organisations think through their outcomes and decide what to measure.

Section 2

Section 2 presents a series of measures, covering each aspect of a person's recovery from drug and alcohol misuse identified in section 1. The measures have been drawn together from existing sources including the European Monitoring Centre for Drugs and Drug Addiction.[3] The selection of measures reflects our assessment of robustness, cost, and ease of use. All of these measures are free to use and easily available to download and copy.

[2] Ni Ogain, E., Plimmer, D, Harries, E, Kail, A and Nicholls, 2013). *The JET pack: a guide to using the Journey to Employment framework*. London: New Philanthropy Capital. http://www.thinknpc.org/publications/the-jet-pack/

[3] http://www.emcdda.europa.eu/eib

Section 3

Section three presents our guidance on how to successfully implement this shared measurement framework. It discusses the practicalities of implementation in frontline services, training needs and the use of technology in enabling data collection and analysis.

The outcomes framework and the measurement tools identified during the research are available on the HRB National Drugs Library website at www.drugsandalcohol.ie.

Section 1: The Drug and alcohol recovery outcomes framework

Introduction

This section presents the factors that influence recovery from drug and alcohol misuse. Based on evidence from the literature and consultation with taskforces, it identifies five groups of factors that contribute to successful recovery: (1) attitudes and feelings; (2) personal circumstances and needs; (3) relationships; (4) employment and skills; and (5) drug use behaviour. This framework is designed to help drug and alcohol taskforces understand and measure the impact they have on a person's recovery from drug and alcohol misuse. It identifies personal outcomes in drug and alcohol recovery and provides a list of measures that can be used to evaluate services and interventions.

The overall goal of drug and alcohol services is to enable people to participate fully in society – emotionally, socially and economically. This may not be a direct outcome of many projects or services but ultimately all taskforces agree that this is what they are working towards. To understand what might help people recovering from drug and alcohol misuse get to this point, we need a set of intermediate outcomes that come about directly as a result of taskforce services. This is what is presented in the framework below. The five groups of intermediate outcomes are:

- **Attitudes and feelings:** this includes many aspects of emotional health and how we feel about ourselves as well as attitudes around drug and alcohol misuse.
- **Personal circumstances and needs:** sometimes referred to by practitioners as 'barriers' or 'presenting needs', these include physical and mental health issues, access to appropriate housing and financial advice as well as criminal activity.
- **Relationships:** this includes both relationships with family and the wider community, peer relationships (positive and negative) and parenting skills.
- **Employment and skills:** this includes both the softer skills needed to succeed in the workplace - things like good communication, interpersonal and self-management skills. It also includes hard outcomes like gaining employment or a qualification.
- **Drug use behaviour:** this is both level of drug use as well as patterns of use. It can relate to reducing use among drug and alcohol users as well as preventing later use through targeted prevention.

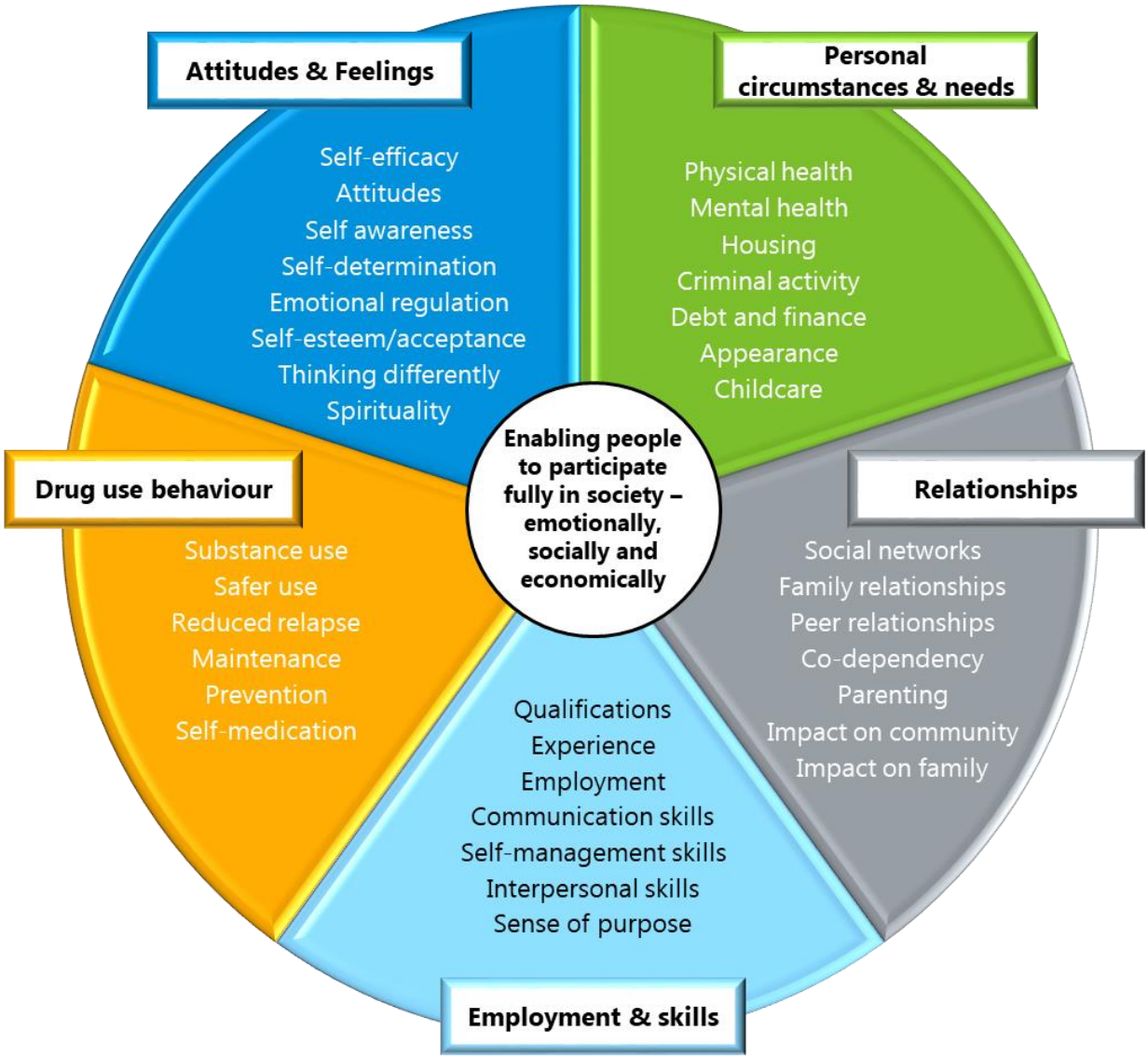


Figure 1: The Drug and Alcohol Recovery Outcomes Framework (updated January 2017)

Diagram includes risk and protective factors.
Enabling factors:

- Services are person-centred
- Engagement with service
- Appropriate referrals
- Relationships with staff/key workers

Outcomes and evidence

Attitudes and feelings

Self-efficacy: a person's belief in their ability to affect situations and have control over the direction of their lives. It is linked to the idea of locus of control and autonomy, either generally or around substance use.

Attitudes: how someone views their drug taking, whether they see it as an accepted behaviour or not. This concept is similar to mind-set. In this context, it will most often refer to a person's attitudes towards drug and alcohol use

Self-awareness: a person's awareness of their substance misuse and how it might affect those around them as well as themselves.

Self-determination: a person's ability to work towards a long term goal. It links to the concept of grit and perseverance. It can be both general and specifically around substance use.

Emotional regulation: how well someone can manage their impulses and reactions. The can be relevant both generally and in reference to substance use.

Self-esteem/self-acceptance: a person's perception of their own value and their confidence in themselves. Self-acceptance is closely linked to this and is around a person's acceptance and contentment of themselves.

Thinking differently: Service users spoke about this outcome as being able to think more clearly, have more focused thinking and improved perspective on their ability to change

Spirituality: service users spoke about the importance of spirituality and faith as something that helped them in their recovery.

Changes in the way that we think or feel play a significant role in why someone might misuse drugs and alcohol in the first place and are also a significant factor in recovery. The recent evidence review looking at the role of social and human capital in recovery from drug and alcohol addiction supports this view. It cites a number of studies that found human and personal capital to be significant predictors of successful recovery.

Psychological traits like self-determination, self-efficacy, motivation, self-regulation, self-esteem and perceived social norms were all cited as important in evaluations of recovery interventions.[4] This is supported by the wider literature looking at the role of self-efficacy and self-belief in health behaviour change. Bandura (1986) has written extensively on self-efficacy as a predictor of successful health behaviour change. For example, in a review looking at cigarette smoking, weight control, contraception, alcohol abuse and exercise behaviours, self-efficacy was a significant predictor of behaviour change and maintenance.[5]

Self-regulation skills are also mentioned frequently in the literature as being a risk factor for substance addiction.[6] It is also a factor, that when improved, has predicted successful recovery

[4] Munton AG, Wedlock E and Gomersall A (2014) *The role of social and human capital in recovery from drug and alcohol addiction.* HRB Drug and Alcohol Evidence Review 1. Dublin: Health Research Board http://www.drugsandalcohol.ie/23078/

[5] Strecher, V.J., McEvoy DeVellis, B., Becker, M, Rosenstock, I.M. The role of self-efficacy in achieving health behavior change. *Health Education Behaviour*. Vol. 13, no. 1 73-92

[6] Fox, H.C., Axelrod, S.R., Paliwal, P., Sleeper, J., and Sinha, R. (2007). Difficulties in emotion regulation and impulse control during cocaine abstinence. *Drug Alcohol Depend.* Jul 10; 89(2-3):298-301.

outcomes.[7] Other studies have supported the role that self-determination and high levels of motivation play in substance use desistance.[8]

Personal circumstances and needs

Physical health: a person receives appropriate treatment and care for any physical health issue. Often this may involve referrals from drug and alcohol services to other relevant health services.

Mental health: a person receives appropriate treatment and care for any mental health issue. Often this may involve referrals from drug and alcohol services to other health services.

Housing: access to affordable, secure, adequate housing. This may involve referrals to appropriate agencies.

Debt and finance: access to appropriate advice and support around debt and financial management. This may involve referrals to appropriate agencies

Childcare: access to childcare is an in an important factor for service users. It may enable them to attend services important to their recovery.

Appearance: Service users spoke about feeling better about their appearance as being an important part of the recovery process – such as being more confident in how they dress and who they look.

People who misuse drugs and alcohol are much more likely than the general population to have personal circumstances that place them at increased risk of being homeless, being involved in criminal activity, having debt and finance issues, and having a physical or mental health issue. In the United States, research has shown that 80% of prisoners misuse drugs or alcohol and nearly 50% are addicted.[9] Similar links are reported in the 2006 study looking at drugs and crime in Ireland.[10]

A study of substance misuse among homeless people in Ireland found that personal drug use was the second most cited reason for being homeless. Three quarters reported lifetime use of an illicit substance and just over half reported problematic alcohol use.[11] Access to appropriate stable housing is therefore a key factor in supporting people in recovery. A recent review in this area showed that stable accommodation is a key factor related to good recovery outcomes.

Many drug users have drug related debt issues which can lead to intimidation by those involved with drug dealing. There are also markedly high rates of physical and mental health issues among problem drug and alcohol users. The World Health Organisation (2002) also identified alcohol as the third highest risk factor for all burden of disease in developed countries. Heavy drinking increases the risk of developing liver failure, coronary heart disease and certain types of cancer. It is also a factor in many accidents and injuries requiring emergency hospital

[7] Cole, J., Logan, T.K., and Walker, R. (2011). Social exclusion, personal control, self-regulation, and stress among substance abuse treatment clients. *Drug Alcohol Depend.* 2011 Jan 1; 113(1):13-20.
[8] Kennedy, K. and Gregoire,, T.K. (2009). Theories of motivation in addiction treatment: Testing the relationship of the transtheoretical model of change and self-determination theory. *Journal of Social Work Practice in the Addictions*.9,2. 163-183.
[9] National Council on Alcoholism and Drug Dependence (2014). *2014 statistics review.* New York: NCADD
[10] Connolly J (2006) *Drugs and crime in Ireland.* Overview 3. Dublin: Health Research Board. http://www.drugsandalcohol.ie/6045/
[11] Lawless, M and Corr, C (2005). *Drug Use Among the Homeless Population in Ireland.* Dublin: Stationary Office. http://www.drugsandalcohol.ie/5950/

admission.[12] Research shows that substance misuse may cause or increase symptoms of mental illness. One study from the UK found that three quarters of drug service users and 85 per cent of alcohol service users had mental health problems. Again, cause and effect is complex in this issue of dual diagnosis.[13] In some cases, substance use may lead to the development of a mental health issue and in other cases, people with mental health issues may misuse substances to block out their symptoms or the side-effects of medication.

Relationships

Social networks: a person is engaging more in positive social networks, which can be family, peers or community, and less in negative networks.

Family relationships: a person has a good and stable relationship with family members.

Peer relationships: a person has positive peer relationships based around shared experience.

Co-dependency: co-dependency with another individual is managed where it has a negative impact on a person's drug-using behaviour.

Parenting: improved parenting skills.

Impact on family: the harm of substance misuse on the family is reduced.

Impact on community: the harm of substance misuse on communities is reduced.

The recent review of the role that human and social capital plays in drug and alcohol recovery found substantial evidence for the positive role of social networks, community and family support. Many studies have found that recovering addicts who maintain positive networks are more likely to refrain from substance misuse. There is also evidence to suggest that those who maintain relationships with negative peer groups (e.g. peers who continue to use) are more likely to relapse. Support from family members can also play a role in providing the practical and emotional support needed to maintain positive health behaviours. Positive peer networks in a person's community can also help recovering addicts better engage in meaningful activities and therefore improve the likelihood of recovery. There is also evidence to show that involving families in therapy and other interventions can improve understanding and therefore the support given during recovery. Including families in therapeutic and other recovery processes can help them support addicts effectively.[14]

Parenting is another area where intervention plays a crucial role. Substance misuse can seriously affect a person's ability to care and parent well. This can affect the development of children and is also a risk factor in children developing substance misuse problems themselves in later life. Parenting well and keeping custody over children is also an important factor in motivating parents to maintain positive behaviours. Therefore, the provision of parenting courses and providing support to families is a key factor in promoting recovery.[15]

[12] Mongan D. and Long J (2016) *Overview of alcohol consumption, alcohol-related harm and alcohol policy in Ireland*. Dublin: Health Research Board. http://www.drugsandalcohol.ie/25697/

[13] Social Care Institute of Excellence (2009). *The relationship between dual diagnosis: substance misuse and dealing with mental health issues.* London: SCIE

[14] Munton AG, Wedlock E and Gomersall A (2014) *The role of social and human capital in recovery from drug and alcohol addiction.* HRB Drug and Alcohol Evidence Review 1. Dublin: Health Research Board http://www.drugsandalcohol.ie/23078/

[15] L Mayes, S Truman (2002). *Handbook of parenting. Substance abuse and parenting.* New Jersey: Lawrence Erlbaum Associates.

Employment and skills

Communication skills: a person's ability to effectively convey their opinion and interact with others.

Self-management skills: a person's ability to organise themselves and their workload effectively, including timekeeping and planning

Interpersonal skills: a person's ability to work effectively with others.

Experience: gaining experience of the workplace or a particular profession – this can be paid, unpaid or through voluntary work.

Employment: gaining and remaining in employment.

Sense of purpose: service users spoke about employment and training as giving them a renewed sense of purpose and the feeling that they were contributing to their community.

Employability skills have an important bearing on success in the workplace, including future earnings. These skills, such as team working, communication, problem solving, and self-management, are highly valued by employers, often far more than educational qualifications.[16] Research in the U.S. has found that non-cognitive traits among high school students, including communication skills, industriousness and self-management, predict higher occupational attainment and earning.[17]

Achieving qualifications is linked to employment prospects and earning potential. The higher an individual's qualifications, the more likely they are to be in employment.[18] Fewer than half of those with no qualifications are in work, compared to nearly 90% of those with graduate-level qualifications.[19]

Employers identify experience of work as one of the areas most commonly lacking among education leavers.[20] Work experience gives people valuable understanding of the workplace and the conduct expected of them. It can also help them enter into the workplace, set realistic aspirations, and develop employability skills.[21]

Additionally, vocational activity including courses, training and employment play a significant role in drug and alcohol recovery, with those successfully taking part in such programmes showing more positive outcomes.[22]

Research has also highlighted the importance of social skills in drug and alcohol recovery. For some people, interventions involving social skills training and the development of interpersonal skills were one factor in supporting addicts of either drugs or alcohol to recover.[23]

---

[16] UK Commission for Employment and Skills (2009) *The Employability challenge*. London: UKCES
[17] Jencks, C et al (1979) *Who gets ahead? The determinants of economic success in America.* New York: Basic Books
[18] Babb, P. (2005) *A Summary of Focus on Social Inequalities.* London: Office for National Statistics.
[19] HM Treasury (2006) *Prosperity for all in the global economy—world class skills. The Leitch Review.* London: HM treasury
[20] UK Commission for Employment and Skills (2011) *UK Commission's Employer Skills Survey 2011: England Results.* London: UKCES
[21] London School of Economics (2013). *Tackling long-term unemployment: the research evidence.* London: LSE
[22] Munton AG, Wedlock E and Gomersall A (2014) *The role of social and human capital in recovery from drug and alcohol addiction.* HRB Drug and Alcohol Evidence Review 1. Dublin: Health Research Board http://www.drugsandalcohol.ie/23078/
[23] Van Hasselt, V., Hersen, M., and Milliones, J. (1978). Social skills training for alcoholics and drug addicts: A review. *Addictive Behaviours*. 3, 221-233.

Drug use behaviour

Substance use: refers to the levels of substance use a person is engaging in.

Safer use: this refers to both the patterns and type of drug use – whether than use is becoming safer (this refers to harm reduction involving the individual. Harm reduction involving others is covered in Personal circumstances – Impact on family & community).

Reduced relapse: reducing potential relapse to greater or more harmful use.

Maintenance: linked to relapse, maintenance refers to maintaining positive patterns of behaviour around substance use or behaviours related to drug use.

Prevention: prevention refers to reduced substance misuse in society as a result of general education and awareness raising as well as targeted early interventions with at risk groups.

Self-medication: service users spoke about reducing their need to self-medicate (often due to improved confidence and better health) as being an important step toward recovery.

Tracking substance use is evidently one of the most important outcomes to understand whether someone is recovering successfully. However, it is not just quantity and frequency that is important in understanding use, but also patterns of use that are associated with more or less risk. For example, informed choice to take part in an opioid replacement programme will be a good outcome depending on how risky someone's substance use was beforehand. Safer use could also relate to a person engaging with a needle exchange programme.[24] It is also important to understand the potential benefit of targeted prevention programmes that reduce the likelihood of later substance misuse. Such prevention programmes have promising results particularly when they are targeted towards at-risk groups, and focus on the development of refusal and self-management skills as well as substance using norms.[25]

Service mapping

To understand the kinds of services delivered most commonly by taskforces, we asked taskforce members to brainstorm and list all services either run directly or funded by taskforces. We also asked taskforce coordinators and staff to provide information on all services and projects in an online survey. This together with our desk research allowed us to produce a categorisation of the most common services and interventions delivered by or through taskforces. This is presented below.

[24] http://pathways.nice.org.uk/pathways/drug-misuse

[25] Griffin, K.W., Botvin, G.J.,Nichols,T.R., Doyle,M.M. (2003). Effectiveness of a universal drug abuse prevention approach for youth at high risk for substance use initiation. *Preventive Medicine*. 36. 1, 1-7.

	Information	Support	Family Support	Counselling / psychotherapy
Description	Information about drugs and alcohol. Facts Questions Details of services Research Policy Publicity Campaigns Advocacy	**Emotional support:** actively listen, support to explore options help to make decisions (helplines, online, drop-in, one to one support, user support groups, family support groups). Different to counselling which explores over a number of contact sessions how current concerns relate to past experiences and behaviours. Provide information or refer to treatment. **Harm reduction support:** focus on prevention of harm caused by drug use rather than prevention of drug use. **Support groups:** members with the same issues come together to share coping strategies, provide support and information, share experience, feel empowered, find sense of community. Inform public about issues / campaign. **Peer support groups:** fully organized and managed by members who are usually volunteers and have personal experience of the issues of the group (groups may also be called fellowships). **Professional support groups:** organized by professionals who may not share the problems of the members. They are often found in institutional settings, e.g., drug-treatment centres, hospitals or prisons.	Aimed at families, carers, partners, friends or others who are concerned about the drug or alcohol use of a person in their life. Safe place to talk and get help. Usually providing practical/ financial/ emotional support and are important in recovery. Support families to practice self-care and empower them to become an agent of change within the family. Help family members to explore circumstances and concerns, provide relevant information, discuss ways of responding and identify social supports. Non-judgemental and problem-solving. Specific family support and education programmes reduce risks to children, problem behaviours and alcohol and drug abuse in children. Share coping strategies. They can provide support and information to other members.	Explore issues related to substance misuse, emotional or mental wellbeing. Group or individual sessions. Improve coping or life skills and support changes in feelings or behaviour. **Psychotherapy**: uncovering and helping people to change unconscious patterns of behaviour developed in childhood to cope with stresses faced at the time. **Counselling**: focus on current crises. Process shorter than psychotherapy. Inc substance misuse / mental health. **Counselling for Substance Misuse:** explore effects on health and wellbeing and readiness to change and difficulties, motivate to pro-actively deal with substance dependence issues. Must take responsibility for recovery but encouraged to seek support from counsellors, sponsors, recovering peers, family members and others. **Counselling / Psychotherapy for Family:** practical and emotional issues, family therapy helps explore how substance abuse affects the entire family and supports them to change interactions among family members.
Examples from workshop	Website/ Helpline	• Key working: assessing, developing care plans, referrals • Crisis intervention/harm reduction • Website/Helpline • Peer groups • After care • Stabilisation • Social enterprises/Men's shed	• Family support – for parents, or members affected, practical support like housing, childcare	• Counselling: group and individual: addiction, CBT, coping skills, motivational interviewing, relationships • Community Reinforcement Approach

	Awareness, prevention, education & training	Medical support	Needle exchange	Treatment
Description	Targeted at various groups - general public, students, community/youth groups, professionals or those accessing drug or alcohol services. **Awareness Programmes:** understand effects of drugs and alcohol and consequences of misuse. **Prevention Programmes:** prevent use of drugs or alcohol or limit the development of problems or further harm associated with them, develop life skills to gain knowledge, values, confidence, specific skills and strategies needed to make informed decisions about drug and alcohol use. Focus on the individual or their surroundings, targeted at entire populations or at groups at risk. **Education and Training Programmes:** educational courses or professional training in community addiction, addiction studies, drugs policy, counselling skills etc. **One off talks:** aspects of awareness, prevention, education, how to support family members as well as details of drug and alcohol services.	Testing for infectious diseases, vaccinations for Hepatitis A and B, wound clinics. Registered nurses/ doctors on-site. Medical care for drug related injuries like abscesses, wounds or skin problems. Diagnosis and treatment of general health problems, referrals to other health services	For injecting drug users. Fixed/mobile. Provide drug users with clean, new, hypodermic syringes and other equipment as well as disposal of used equipment. Reduce risks associated with injecting and sharing injecting equipment (for example, contracting Hepatitis C, HIV, etc.) through facilitating changes in behaviour.	**Opioid Substitution Treatment (OST):** controlled drug prescribed in place of the drug addicted to. Stabilises drug intake and lifestyle while stopping illicit drug use and associated unhealthy risk behaviours. Reduces risk of overdose, blood-borne infections and offending. **Detoxification Programmes:** medically supervised treatment program intended to lessen the physical effects of addictive substances. **Inpatient/Residential Detox:** based in drug treatment facilities (inc. hospitals & psychiatric wards). **Non-residential Detox:** provided in health care or addiction treatment facilities over regular sessions where support from doctors, nurses, psychiatrists and other staff may be available. **Community Detox protocols:** developed to reduce or stop use of methadone or benzodiazepines (prescribed or illicitly sourced)
Examples from workshop	• Outdoor education • Early intervention and prevention: health promotion, awareness raising and education in schools, peer education, work with youth groups. Targeted intervention for at risk youth groups. • Education, training and employment: accredited level 3-7 courses, community addictions course, work experience, supported work placements, qualifications, and progression into workplace.		• Needle exchange	• Rehabilitation: drop in and residential • Community detox/methadone

It will be important for taskforces to recognise the outcomes in this framework that result from different types of drug and alcohol services. As mentioned previously, we recommend using theory of change or logic models to understand the specific outcomes of a particular project or service. However, we have also grouped services that are most likely to lead to outcomes in this framework in the diagram below. This can be used as a rough reference for taskforces when trying to understand the type of outcome they may want to measure for a particular service or project.

Figure 2: Recovery outcomes mapped to typical drug and alcohol services

Section 2: Measures

The tools included in this list have been chosen based on our assessment of robustness, cost, and ease of use. They are free to access and, are generally short in length. We have also tried to identify tools that are applicable to the widest age group possible, so they can be used by organisations working across the field of drug and alcohol misuse. All recommended scales have been tested for their psychometric properties and have good reliability and validity. Taskforces can use the tables below to search for a relevant measure under each outcome.

Attitudes and feelings

Scale	Outcome	No. items
Self-efficacy		
Self-efficacy & self-control	This tool measures attitudes around self-control and self-efficacy. It can be used before someone begins a self-control program to determine their attitudes before the program, and then again after the program to determine if attitudes have improved.	20
General self-efficacy	The General Self-Efficacy Scale is correlated to emotion, optimism and work satisfaction. Negative coefficients were found for depression, stress, health complaints, burnout, and anxiety.	10
Drug avoidance self-efficacy scale	Clients are asked to imagine themselves in a particular situation and to rate their level of confidence (self-efficacy) to resist drug use in that situation. Each of the scale items represents a different situation in which a drug user might be tempted to use drugs. The DASES is a relatively brief and easy to use measure of self-efficacy. It is useful as an outcome measure because it has been demonstrated to predict subsequent drug use. There is evidence supporting the reliability and validity of the scale, although its use has been restricted to young multiple drug users (aged 16-30).	16
Attitudes (towards drug and alcohol use)		
Alcohol beliefs	The role of expectancies in the initiation and maintenance of drinking behaviour among adolescents has been demonstrated to be an important mediator in recovery. The Alcohol Expectancy Questionnaire-Adolescent, Brief (AEQ-AB) was developed as a brief but useful tool for clinicians to predict drinking behaviour.	7
Drinking related locus of control	The DRIE was developed to define an individual's beliefs about the extent to which life events are under personal control (internal locus of control) or under the influence of chance, fate, or powerful others (external locus of control). The DRIE assesses these beliefs specifically with respect to the individual's perceptions of control around alcohol, drinking behaviour, and recovery.	25

Marijuana beliefs	The Marijuana Effect Expectancy Questionnaire-Brief (MEEQ-B) is intended for assessing marijuana expectancies in an adult population. The MEEQ-B was developed to test adults on marijuana expectations, and provide a sensitive but brief tool for use in fast-paced correctional/ clinical environments.	6
Attitudes to drug use	Some evaluations have been concerned with attitudes towards use. In general, while attitudes are important context measures, they do not predict actual behaviour very well. They should not be used as a substitute for measures of behaviour (prevalence).	12
Beliefs about consequences	Beliefs about the consequences of drug use can be categorised in two ways - whether they are (i) positive or negative and (ii) short-term or long-term. The literature suggests that such beliefs are more closely related to behaviour if the focus is on personal use and with reference to specific circumstances.	14
Self-awareness		
Emotional intelligence	This self-assessment questionnaire is designed to measure the various competences of emotional intelligence including: self-awareness, motivating oneself, managing emotions, empathy and social skills.	33
Self-determination		
Grit & determination	The Grit Scale assesses an individual's ability or propensity to stick with things over a period of time.	12
Assertiveness	Many programmes attempt to teach people the skills to withstand pressures from others. Thus, measures of assertiveness are appropriate in deciding if such interventions have been effective.	5
Decision-making skills	The measurement of decision-making skills is particularly relevant where a programme emphasises personal decisions and the effort to equip people with the skills to withstand social pressures.	8
COPE	The COPE Inventory was developed to assess a broad range of coping responses. The inventory includes some responses that are expected to be dysfunctional, as well as some that are expected to be functional.	60
Emotional regulation		
Emotional regulation	The Emotion Regulation Questionnaire asks about emotional life, in particular, how emotions are regulated and managed. It looks at emotional experience (what you feel like inside) and emotional expression (how you show your emotions in the way you talk, gesture, or behave).	10
Self-esteem/self-acceptance		
Self-esteem (Rosenberg)	Self-esteem reflects a person's overall subjective emotional evaluation of his or her own worth. The scale measures state self-esteem by asking the respondents to reflect on their current feelings.	10
Thinking differently (clearer or more focussed thinking as well as positive thinking)		

Positive reframing subscale from the COPE inventory	COPE was developed to assess a broad range of coping responses. The brief COPE was designed to measure responses following surgery but we have adapted this to ask about responses during the recovery process. The positive reframing subscale measures positive thinking.	2
Mindfulness questionnaire	The mindfulness questionnaire measures how well a person is aware of their thoughts and experiences. It measures focuses and clear thinking as well as paying attention to what is happening at the present time.	15
Spirituality		
Spirituality subscale from the COPE inventory	COPE was developed to assess a broad range of coping responses. The brief COPE was designed to measure responses following surgery but we have adapted this to ask about responses during the recovery process. The positive reframing subscale measures positive thinking.	2

Personal circumstances and needs

Scale	Outcome	No. items
Physical health		
Health Questionnaire	The Health Questionnaire provides a reliable and valid assessment of physical health. It can detect improvements in physical health following addiction treatment. The scale has been used with male and female adult and elderly samples from clinical and non-clinical populations,	144
Health Questionnaire (EQ-5D)	Applicable to a wide range of health conditions and treatments, this scale provides a simple descriptive profile and a single index value for health status.	16
Mental health		
Mental wellbeing (WEMWBS)	The Warwick-Edinburgh Mental Well-being scale was developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing.	14
Patient Health (PHQ9)	A multi-purpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.	9
Housing		
Housing	Appropriate assessment and referrals.	N/A
Criminal activity		

Addiction severity index - crime	Contains descriptions of problems with criminality/criminal lifestyle including assessment of drug and alcohol use, needs and risk of recidivism. Useful for treatment planning, evaluation and treatment research. Requires some training / experience of interviewers.	14 modules
Debt and finance		
Financial behaviour	Developed to assess the current state of financial literacy or general financial situations of participants.	19
Financial self-efficacy	The Financial Self-Efficacy Scale measures how respondents manage certain financial problems and how they cope with setbacks. The FSES can help programmes to better understand, guide, and motivate their clients with financial management.	6
Appearance		
Appearance question	This question is taken from Current Thoughts Scale (Heatherton & Polivy, 1991) – A measure of state self-esteem. It measures overall satisfaction with appearance – this could refer both to physical appearance as well as dress, cleanliness and hygiene.	1
Childcare		
Childcare	Services should assess whether a beneficiary has access to appropriate childcare and refer if necessary to relevant support.	

Relationships

Scale	Outcome	No. items
Social networks / Peer relationships		
Normative Influences	This scale measures the influence that our peers can have in leading us to conform in order to be liked and accepted by them.	12
Normative influences (approval)	Another important feature of peer influence is perceived approval. This scale includes a number of items on peer approval ranging from immediate peers (best friends) to remote peers (people of same age).	12
Need to belong	The need to belong is one of the most fundamental and well-researched human motives. The need to belong is a ''strong desire to form and maintain enduring interpersonal attachments.'' This Need to Belong Scale is the most recent and empirically sound of the current need to belong measures.	10
Social networks	Assesses the social networks surrounding the individual including family and friendships	6

Perception of social support	It has been found that degree of perceived social support from parents and friends is a restraining factor in relation to drugs. Thus, a measure of this may indicate whether a programme brought about this outcome.	6
Family relationships		
Bonding to parents and family	There is a good deal of evidence that a young person's bonding or attachment to their family is an important restraining factor in relation to drug use. In this scale, the items are built around the extent to which respondents perceive that they get on well with their family and on the importance that they attach to this relationship.	11
Family functioning	This is a subscale measuring general family functioning taken from the McMaster Family Assessment Device which includes seven subscales: Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behaviour Control and General Functioning.	12
Parenting		
Parental risk factors	Parental risk factors can be divided into broad categories that include the following: (i) factors specific to drugs, especially approval, (ii) factors relating to supervision and regulation, and (iii) home atmosphere, especially parental conflict. This scale focuses on each of these areas.	12
Parental regulation	In the literature on parental regulation, two aspects of strictness and supervision are found to be important in relation to drugs and overall level of supervision. Of the five items, two are concerned with overall regulation by parents while three focus on perceived parental regulation of use of drugs.	5
Perception of parental conflict	Parental conflict has been found to be associated with many problems of substance use. This scale is concerned with the perception of this conflict by children and adolescents.	6
Co-dependency		
Co-dependency	This scale measures co-dependency, defined as "a dysfunctional pattern of relating to others with an extreme focus outside of oneself, lack of expression of feelings, and personal meaning derived from relationships with others". The scale is not specific to drugs and alcohol but highlights co-dependent personality traits.	16
Impact on Family		
	Impact on family and community outcomes do not have specific measurement scales due to the wide range of possible causes and effects. Instead, practitioners are encouraged to identify issues on a case by case basis.	
Impact on community		
	Impact on family and community outcomes do not have specific measurement scales due to the wide range of possible causes and effects. Instead, practitioners are encouraged to identify issues on a case by case basis.	

Employment and skills

Scale	Outcome	No. items
Communication skills		
Communicative Competence scale	Good communication is an important skill for the workplace. The communication competence scale measures different aspects of communication.	36
Self-management skills		
Individual Protective Factors Index, self-control scale	Self-management is an important factor both in reducing likelihood of relapse but is also an important skill for the workplace. The Individual Protective Factors Index self-control scale measures people's ability to control their impulses and emotions.	6
Interpersonal skills		
Communicative Competence scale	Interpersonal skills play an important role in the workplace and are valued by employers	36
Qualifications		
Log of achievements/ qualifications	Vocational activity including courses, training and employment play a significant role in recovery. Measuring outcomes in this area is straightforward as it requires simple tracking of any qualifications gained.	N/A
Experience		
Work experience questionnaire - designed for this framework	Work experience gives people valuable understanding of the workplace and the conduct expected of them. Use the work experience questionnaire to track work experience in a consistent way.	4
Employment		
Employment questionnaire- designed for this framework	Employment plays a significant role in recovery, with many former addicts citing motivation to work as a factor in recovery. Use the employment questionnaire to track employment outcomes in a consistent way.	7
Sense of purpose		
Life Engagement Test	The Life Engagement Test is designed to measure purpose in life, defined in terms of how much a person engages in activities that are personally valued.	6
Flourishing scale	The Flourishing Scale measures purpose and meaning in life as well as contributions to the happiness and well-being of others.	8

Drug use behaviour

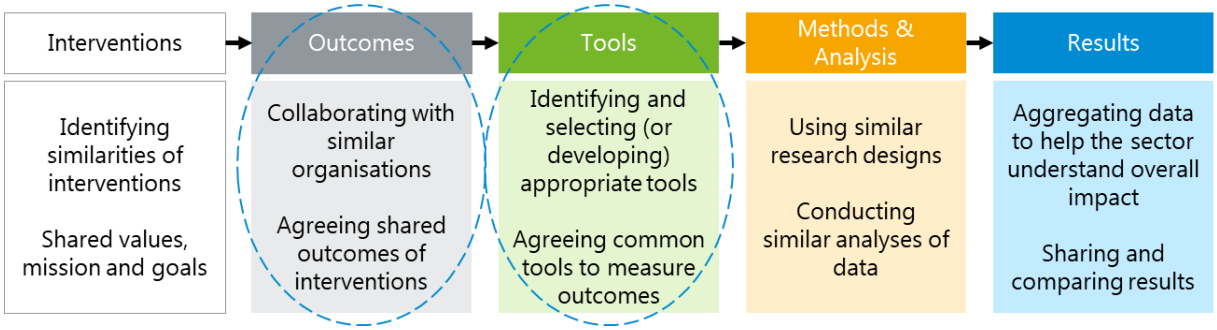
Scale	Outcome	No. items
Substance use / Maintenance / Relapse		
Stages of Change Readiness and Treatment Eagerness Scale (drugs)	SOCRATES is an experimental instrument designed to assess readiness for change in drug misusers. Client motivation for change is an important predictor of treatment compliance and eventual outcome. The SOCRATES can assist clinicians with information necessary for treatment planning. The SOCRATES has been found to be an important predictor of long-term drug treatment outcome.	19
Stages of Change Readiness and Treatment Eagerness Scale (alcohol)	SOCRATES is an experimental instrument designed to assess readiness for change in alcohol abusers. Motivation for change is an important predictor of treatment compliance and eventual outcome. SOCRATES has been found to be an important predictor of long-term alcohol treatment outcome.	19
SOCRATES for males' significant other	Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) from the perspective of a loved-one of a male drug-user	30
SOCRATES for females' significant other	Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) from the perspective of a loved-one of a female drug-user	31
Addiction Severity Index	Designed to provide basic diagnostic information on a client prior, during and after treatment for substance use-related problems, and for the assessment of change in client status and treatment outcome. The structured interview should be carried out by a skilled and trained technician.	161
Christo Inventory for Substance Misuse Services	The CISS is a simple general index of client problems. It has been used with both drug and alcohol services. CISS was developed to find out workers' impressions of their clients in a quick, standardised and reliable way.	10
Maudsley Addiction Profile (MAP)	The MAP measures problems in four domains: substance use, health risk behaviour, physical and psychological health, and personal/social functioning.	45
Coping behaviours inventory (alcohol)	The Coping Behaviours Inventory (CBI) was designed to assess the behaviours and thoughts used by alcoholics to prevent, avoid or control the resumption of heavy drinking. Use of the CBI in outcome studies has shown the measure to be a sensitive indicator of change following addictions treatment. The scale can be used with male and female alcoholics from different age groups (adolescents, adults and the elderly).	36
Safer use		

Blood borne virus transmission risk	The BBV-TRAQ assesses the frequency with which injecting drug users have participated in specific injecting, sexual and other risk-practices in the previous month that may expose them to blood-borne viruses. The instrument consists of 34 questions that make up three sub-scales measuring frequency of current injecting risk behaviours (20 questions), sexual risk behaviours (8 questions) and other skin penetration risk behaviours (6 questions).	34
Injecting risk	To help assess levels of injecting risk behaviour	17
HIV/AIDS risk	To assess HIV/AIDS risk among clients of substance misuse treatment programs. Includes risk behaviour associated with injecting substance use and sexual relationships.	19
Prevention		
Problem behaviour (youth)	A large body of evidence testifies to the relationship between self-reported problem behaviour and drug use. The forms of problem behaviour will be influenced by the cultural context of the evaluation and by the nature of the intervention.	8
Self-medication		
Self-medicating scale	This scale measures people's beliefs about self-medication. It measures reluctance to self-mediate, ease of self-medication and beliefs about letting things run their course.	9
Enabling factors		
Relationships between staff/key works and service users.	Recovery-Promoting Relationships Scale. This scale measures a number of aspects of the relationship between a service users and a key worked. Each aspect is related to behaviours and attitudes of staff that promote recovery. There is also an 8-item subscale measuring the core relationship that can be used separately.	24

Section 3: Guidance on implementation

Next steps

As mentioned in the introduction, understanding service outcomes and having access to relevant measures is just one part of implementing a shared measurement framework. There are a number of steps that come after this point that need to be considered.



The blueprint for shared measurement profiled twenty different approaches to implementing shared measurement to understand the key success factors. The most important stages are summarised in the diagram above. As discussed, there are a number of stages that come after the identification of tools and measures:

- Training and support
- Analysis
- Technology
- Using results

Training and support

Implementing or changing a performance/impact monitoring system will require training for staff that input data or interpret the outputs. Without training, you risk not being able to understand your results and so will not be able to implement changes to your projects. Whether you need to bring in an external trainer will depend on your internal training capabilities, the existing skills and knowledge of your staff and the complexity of your system and what you do. We recommend that organisations consider going on a training course before developing a measurement approach. There are three aspects to the skills that taskforces may need support with.

One is related to taskforces understanding and identifying the relevant outcomes for their service or services. We believe that using theory of change would be a useful tool in helping services to think about the process of change a beneficiary goes through when accessing a particular service. This helps services to identify the most relevant intermediate outcomes they may want to measure with the questionnaires outlined in this guide.

The second aspect is skills and guidance in using the measures recommended in this framework with service users. Once taskforces begin to use measures, it is important that similar research

designs are used across similar service - so for example, a group therapy programme run by different taskforces should be evaluated using a baseline and follow up questionnaire over a similar timeframe. Again, training and guidance on evaluation would help taskforces understand how to use the measures in this report most effectively.

Finally, taskforces may want to support staff with analysis and interpretation of results. Technology and software could help with the automation of analysis.

Technology

One of the most crucial steps in developing shared measurement is translating a shared outcomes framework (such as the outcomes and measures outlined in this report) into an online platform. This is to enable organisations to easily choose outcomes and measure their impact without having to input data and analyse results manually. This will provide organisations with a low cost and easy to use tool while at the same time gathering data consistently so they can track their effectiveness and learn how their results compare to similar organisations. Data collection, storage and analysis will quickly become resource intensive without a technology or software solution. Some organisations use simple spreadsheets to collect and analyse data - which is sufficient if the data is low volume and the analysis is relatively straightforward. Salesforce is being increasingly used as a software solution in collecting outcomes data; it can be used both to administer questionnaires, collect and analyse data. This could be a potential option for drug and alcohol taskforces.

Using results

Finally, the most important goal of this framework is to ensure that any data collection is used to learn about what is and is not working when it comes to drug and alcohol recovery. It is essential that results are easily understood and presented in a way that allows frontline staff to make changes and improvements to their services. It is also important to think about how any shared outcomes data is aggregated and compared to understand the relative effectiveness of interventions. Again, software can help with any future aggregation or comparison.

Conclusion

This framework provides the first step in supporting drug and alcohol task forces to think about the common outcomes of their work. It provides a resource of outcomes in a number of domains that have been highlighted by the literature on recovery as well as by taskforces. It also provides recommended questionnaires and psychometric scales to measure these outcomes.

However, this framework is just one step towards realising the full benefits of shared measurement. Taskforces need to understand how their particular work contributes to the outcomes in this framework. Theory of change could be a useful tool to understand this question.

Taskforces will also need further support and training in using questionnaires, gathering data and analysing results. We believe that a software solution could provide a solution to some of the burden of individual data collection and could also improve consistency in data collection.

Finally, as mentioned above, the main goal of this framework is to supply frontline services with the tools needed to understand the successes of their work. Data should always be collected with the aim of improvement in mind and we hope that the measures in this report will be used in this way.

Ultimately, the goal of measuring outcomes in a consistent way is to truly understand what services and projects are most effective at helping people - whatever sector it is applied to - and the goal of this framework is no different.